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Readmissions NEWS

Catching Up With …

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James L. (Larry) Holly, MD

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- Clinical Associate Professor, Department of Internal Medicine, Texas A&M Health Science Center College of Medicine
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- Member, HIMSS and NQF technical committees; numerous SETMA awards for IT innovations
- MD degree and 2012 Distinguished Alumnus, UT Health Science Center School of Medicine, San Antonio

***Readmissions News*:** *Looking at the national scene, is the modest downturn in hospital readmissions rates a product of Federal government penalties under the Hospital Readmissions Reduction Program (HRRP), Federal government incentives via demonstration grants, or simply hospitals and their partners responding to the new value-based purchasing environment?*

Larry Holly: Without research, we can't make absolute judgments about this downturn, but we can make informed observations. Even though modest, the population involved in the downturn is so large, it is significant. It probably represents the "low hanging fruit" which could have been achieved much earlier. The HRRP focuses attention on the problem and certainly deserves some of the credit. Hospitals' and healthcare providers' are paying attention to all patients' transitions of care which will soon make an even bigger difference in readmissions.

Readmissions News: *Will the addition of new procedures to be covered under HRRP made a big difference in readmissions reductions strategies, or is the marketplace moving toward all-cause readmissions anyway?*

Larry Holly: The answer is clearly yes to both questions. Typically providers do not treat one population of patients different from another. Once a strategy yields positive results with one group, it is natural to apply the principles to others as well. The effectiveness of "alternative payment models" -- and particularly "advanced alternative payment modes" such as Accountable Care Organizations where there is upside and downside accountability -- is increasingly being verified. The two-pronged Federal programs, i.e., rewarding the care patterns and outcomes which are being encouraged, and penalizing the care patterns and outcomes which are being discouraged, are proving effective. The caution, as we have seen with the Affordable Care Act and with the Meaningful Use program, is that the pressure to change must be modulated so that it is not so great as to make success seem futile, ultimately having a net negative effect. The pressure must be great enough to move the process forward, but not so great as to discourage providers and have them "give up."

Readmissions News: *You have had good success at SETMA in reducing avoidable readmissions. What are the* key elements of that success?

Larry Holly: Being a medium size multi-specialty group, SETMA has discharged over 21,000 patients from the hospital in the past five years. During that time and before, we have worked on reducing readmissions by developing an effective transitions of care process. SETMA's Care Transition involves:

1. Evaluation at admission -- Transition issues are addressed on admission such as: "lives alone without help being available," financial barriers to care, durable medical equipment needed for patient safety, medication reconciliation done on admission, etc. A "Hospital Care Plan" is prepared by the provider and given to the patient at admission. This document addresses why the patient is being admitted, what he/she can expect, how long he/she will be hospitalized and his/her potential for readmission upon discharge.

Catching Up With …James L. (Larry) Holly, MD continued

2. Fulfillment of Care Transitions Quality Metric Set – upon discharge these metrics published by the Physician Consortium for Performance Improvement are fulfilled. They address all of the critical transition of care issues needed. SETMA's performance on these metrics by provider name are published at www.setma.com for the past five years.

3. Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan at discharge. In the past ten years, this document has been our transition of care document and in the past five years, this document has been completed at the time the patient leaves the hospital 98.6% of the time.

4. Post Hospital Follow-up Coaching -- a 12-30 minute call made by members of SETMA's Care Coordination Department to the patient the day following discharge. If the patient is vulnerable or at risk of readmission subsequent coaching calls are scheduled at that tie.

5. Follow-up visit with primary provider -– the last and critical step in Care Transitions. If the patient is high risk for readmission as judged at discharge, they are seen within two days; if they are not high risk, they are seen within five days. The care transition process, which began upon admission, is not considered to be complete until the patient is seen in the clinic and until they are established in the outpatient setting.

Medication Reconciliation is done upon admission, discharge, in the care coaching call and in the outpatient follow-up call. Also, SETMA has designed a tool and is auditing our performance on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). The attention this focuses upon patient activation and engagement is contributing to improved readmission rates.

It is SETMA's judgment that the problem of readmissions will not be solved by more care: more medicines, more tests, more visits, etc., but rather by redirecting the patient's attention for a safety net away from the emergency department. The problem will be solved by our having more proactive contact with the patient and by more contact with the patient and/or caregiver in the home: home health, social worker, provider house calls. In the future, the problem will be solved by the patient and/or caregiver having more contact electronically (telephone, e-mail, web portal, cell phone), giving them immediate access to their provider.

Readmissions News: *How big an impact do you think the growth of patient-centered medical homes (PCMHs) and Accountable Care Organizations (ACOs) is having on readmission rates?*

Larry Holly: With the activation and engagement of patients, along with shared-decision making and patient-centric conversations, we think that PCMH is having and will have a significant impact upon readmissions. SETMA is certified by AAAHC and recognized by NCQA as a medical home from 2010-2016. We will be surveyed by URAC, December 19-20 and by Joint Commission in March 2014 for medical home. We participate in a federally qualified ACO. We believe that both contributed positively to our readmission efforts.

Readmissions News: *You serve Medicaid and uninsured people at SETMA as well as those with commercial insurance or Medicare coverage. Do the readmissions rates and readmissions strategies differ among these groups?*

Larry Holly: Poverty and lack of insurance contribute greatly to all categories of healthcare problems, including readmissions. In these groups, the need for resources is much greater, and experience with accessing of the healthcare system is limited. When resources are made available, their outcomes are excellent. One uninsured patient of SETMA's was hospitalized frequently and was on numerous medications. The patient's dental health was poor. SETMA's Foundation undertook to pay for her dental reconstruction. The cost was to be $10,400 and we asked the dentist to make a $4,000 contribution to our Foundation. He did, and we paid the full fee. Since the dental work was completed four years ago, the patient has not been hospitalized once and is off all medications. This is only one story out of many. The patient is grateful and SETMA's partners, who give $500,000 a year to the Foundation, providers and staff are proud of the care they give. The savings to the healthcare systems has been multiples of the cost of her dental work, in addition to the patient's safety and quality of life.

Readmissions News: *Finally, tell us something about yourself that few people would know.*

Larry Holly: SETMA started a PCMH externship for senior medical students and primary care residents. In addition to transforming healthcare today, we have a passion for contributing to the training of the next generation of nurse practitioners, physician assistance, and physicians. My wife and I endowed a Distinguished Professorship in PCMH at my school of medicine.